Credit Card Authorization

Office Name: _____ Account No,: _____

I, _____ , (as shown on card),

authorize the ***International Orthodontic Services (IOS)*** to charge my credit card:

Number _____-_____-_____-_____. Card Type: Chose One Type _____

Exp. date_____/_____. CVV _____ Zip Code _____

Billing address of credit card:

Address _____

City. _____. State. _____. Zip Code. _____

Contact Phone Number. _____

Pay the amount on my account as follows: (Please check one)

- ☑ By invoice (will charge after 2-3 days of the issued invoice)
- ☐ By Statement (all invoices of the month will be charged at the end of each month)
- ☐ For one invoice only. Invoice No, _____. Amount $ _____

I request to have my invoice or statement sent by:

- ☑ Mail:

Address _____

City. _____. State. _____. Zip Code. _____

- ☐ Email _____

_____ _____

Authorized Signature (type your name) Date

This credit/debit card will be used for the charges above, if an authorization from the bank is approved.

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